

REGULATION OF RESIDENCY TRAINING*

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BACKGROUND

IN 1984 LIBBY ZION, an 18-year-old woman, was admitted to a major New York City teaching hospital, where she died in less than 24 hours. Repercussions from this single instance of patient care gone awry still reverberate through the medical education community.

From the grand jury investigation concerning the circumstances of Miss Zion's death came several recommendations concerning emergency room staffing, the supervision of residents in training, and the hours assigned to residents. In response to the grand jury, my colleague on the podium, Dr. Axelrod, appointed an Ad Hoc Advisory Committee on Emergency Services to analyze the grand jury's recommendations. That committee's recommendations are now policy in this state and the subject of discussion and debate in many other jurisdictions.

The death of Miss Zion was unfortunate, whatever its circumstances. More significantly, her death stimulated a chain of events that required the medical education community to review and evaluate the assignments of residents and policies governing their supervision. However belated such a reevaluation may have been, it is clear that the medical education community has now begun to recognize its larger responsibility that goes beyond the debate of resident assignments and supervision, and extends to the educational and personal environment in which residents live.

A number of professional organizations have followed the lead of New York in reviewing the format of residency training, and a variety of changes have been implemented or are planned. While it would be naive to assume that the issues raised by the Zion case have been resolved completely, I

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believe that the profession has shown that it can respond to public concerns reasonably promptly. If I had to make a wish about the regulation of residency training, it would not be that our community had responded to public concerns after the Zion case more quickly. On the whole, I think our reaction has been rather prompt. My wish would be that the profession had been more perceptive in recognizing the issue and making appropriate changes in training prior to its becoming a cause celebre, hyped up by the media. Negotiations within and between professional societies were made considerably more difficult because they had to be undertaken in the glare of media publicity. It is also unfortunate that long-overdue changes in structuring residency training were not initiated within our own community prior to the serendipitous stimulus of the Zion case. This fact alone has, I believe, damaged our profession's reputation with the public, and certainly with young physicians who had been trying for some time to move this issue higher on the agenda of graduate medical education reform.

I shall not recount for this sophisticated audience the history of house staff development in this country. Some of you, like me, are of an era where interns and junior residents worked every other night. A reflection on today's house staff schedules where residents are on call every fourth and fifth nights may lead to the superficial conclusion that residency training has become easier. In point of fact, this is not the case. In the past, as now, resident physicians are trained to make critical decisions about seriously ill patients. However, in contrast to prior practice, the teaching hospital has experienced dramatic changes in the past few years: patient stays are shorter, more procedures and treatments are scheduled to be carried out in a shorter period of time, and the less ill do not enter the hospital at all but are treated on an ambulatory basis. As a result, today's residents make more decisions about sicker patients than their predecessors. To these clinical stresses must be added the physical stress attendant in residency, which some claim leads to "compassion fatigue," and the personal stress that for many accompanies the start of repayment of what may be a major educational debt. In the light of these changes in the environment, training practices appropriate to an earlier time may need to be reexamined to be certain that they meet sound educational objectives and satisfy the need for excellent service to patients, as well as a more normal existence for house staff.

AAMC POSITION

In March 1988, following the extensive debate in New York on the issue of house staff hours and supervision, the Association of American Medical

Colleges promulgated its position.¹ These recommendations were presented as guidelines, not as formulas, for each hospital to consider and to utilize in a manner appropriate to its setting, role, and resources. Our recommendations were:

Every teaching hospital should have governance and operational mechanisms to ensure that residency programs not only have inherent educational value but also enhance the quality of care provided to patients.

Teaching hospitals and residency programs should have policies and procedures specifying the level of supervision which faculty and other supervising physicians exercise over residents at each level of training.

Every teaching hospital should adopt general guidelines for residents' working hours according to specialty, intensity of patient care responsibilities, level of experience, and educational requirements. In order that decisions about the care of patients are not impaired by fatigue, the hours actually worked should not exceed 80 hours per week when averaged over four weeks.

Teaching hospitals and residency programs should have policies which prohibit unauthorized moonlighting. The total working hours for residency and authorized moonlighting should not exceed 80 working hours per week when averaged over four weeks.

The Accreditation Council for Graduate Medical Education should inform each Residency Review Committee that it must include in its program surveys an assessment of the policies and operating procedures that provide for the direct and indirect resident supervision by program faculties.

Surveyors should examine residents' schedules, and visiting review committees should include an assessment of the working hours assigned to residents in determining a program's accreditation status.

Changes in resident hours should be phased in gradually, without compromising the quality of patient care or the educational goals of residency programs.

All public and private purchasers of hospital services should support teaching hospitals' efforts to ensure high quality patient care by reimbursing the hospital for all of the incremental costs incurred as a result of altering resident supervision and assignment policies.

Despite a difference in opinion among its community, the Association was finally able to achieve a consensus on this set of recommendations, even though a significant minority continued to believe that a rigid delineation of hours would impinge on educational goals and objectives in certain specialties.

DEVELOPMENT OF ACGME POSITION

Other organizations also addressed the issue in policy positions. The Residency Review Committee for Internal Medicine set the resident's work week at 80 hours, and the American College of Physicians reports that most programs are already in compliance with this standard. The response of internal medicine may not have been entirely free of self-interest. Internal medicine has had several years of disappointing results in the National Resident Matching Program, and an official of the American College of Physicians admits that competition from other specialties has played a role in forcing internal medicine to address quality of life issues for residents.

Since the time that the Association of American Medical Colleges promulgated its position, it has been working with a number of other organizations to achieve its recommendations. A key focus of activity has been in the Accreditation Council for Graduate Medical Education, which has the ultimate responsibility for accrediting residency programs. In June 1989 the ACGME released a preliminary draft revision of the general requirements section of the essentials of accredited residencies.² Sections II.C and II.D stated:

C. Resident Duty Hours

Resident duty hours and on call schedules must not be excessive. All residents should, on average, be able to have at least one 24-hour day out of seven free of program duties and should be on call no more often than every third night. Duty hours must be consistent with the special requirements that apply to each program.

D. Supervision of Residents

Institutional policies must ensure that all residents are adequately supervised. The level and method of this supervision must be consistent with the Special Requirements that apply to each program. There must be reliable methods of communication between residents and supervising physicians.

You will note that the original draft, rather than specifying working hours, tried to define parameters for free time and on-call rotations.

In November 1989 an AAMC committee, chaired by Dr. Thomas Morris of Presbyterian Hospital, reviewed the ACGME draft and submitted an alternate version to the ACGME.³ In this version the relevant section stated:

Institutional policies must ensure that all residents are adequately supervised. The level and method of this supervision must be consistent with the Special Requirements for each program.

1. The educational goals of the program and the learning objectives of residents should not be compromised by an excessive reliance on residents to fulfill institutional service obligations.

2. Resident duty hours and on call schedules must not be excessive and must be consistent with the Special Requirements that apply to each program. All residents

should, on average, have at least one 24-hour day out of seven free of program duties and should be on call no more often than every third night.

3. Duty hours and night and weekend call for residents must reflect the fact that responsibilities for continuing patient care are not automatically discharged at any given hour of the day or any particular day of the week. However, programs must ensure that residents are given reasonable duty and call assignments. Backup support should be provided for residents when their patient care responsibilities are especially difficult or prolonged.

In June 1990 the ACGME approved a final revision of the general requirements and forwarded it to its five sponsoring organizations.⁴ At that time section II.C stated:

Institutions must ensure that their residency training programs provide appropriate supervision for all residents as well as a working environment and duty hour schedule that are consistent with proper patient care and the educational needs of residents.

1. Residents must be supervised by teaching staff in such a way that the trainees assume progressively increasing responsibility for patient care according to their level of training, their ability, and their experience. On-call schedules for teaching staff must be structured to assure that supervision is readily available to residents on duty. The level of responsibility accorded to each resident must be determined by the teaching staff.

2. Each residency program must establish formal policies governing resident duty hours and working environment that are optimal for both resident education and the care of patients.

a. Resident duty hours and on-call schedules must not be excessive. All residents should, on average, be able to have at least one 24-hour day out of seven free of patient care responsibilities and should be on call in the hospital no more often than every third night when averaged over a four-week period. Duty hours must be consistent with the general and special requirements that apply to each program.

An *exception* [emphasis added] to the above standard may be granted if sufficient reasons exist for a specialty to conduct education with a different method of setting appropriate duty hours. Such exceptions shall be alternate provisions for on duty hours and should be delineated in the Special Requirements specifically approved by the ACGME upon recommendation by an RRC based on a sufficient educational rationale.

b. The educational goals of the program and learning objectives of residents must not be compromised by excessive reliance on residents to fulfill institutional service obligations. Duty hours, however, must reflect the fact that responsibilities for continuing patient care are not automatically discharged at specific times. Programs must ensure that residents are provided backup support when patient care responsibilities are especially difficult or prolonged.

While the version sent to the parent organizations of the ACGME did not specify a work week of no more than 80 hours when averaged over a four week period, on the whole the AAMC believed that the ACGME approach was consistent with its intent to limit the resident work week and provide free time for residents.

ABMS RESPONSE

When the general requirements were presented to the American Board of Medical Specialties for ratification, there were objections from the surgical boards that the language was too specific in its requirements for 24 hours free of hospital duties every seven days and every third night on call. The surgeons believe that their residents must see patients on whom they have operated every day. They cannot countenance having residents claim that they have an assigned day off. There were further arguments about the general requirements being too specific. The surgical boards did not believe that adequate relief was afforded by the language that said that exceptions could be approved as part of the special requirements of any specialty. Accordingly, the ABMS submitted alternate language that stated:⁵

Assignments of in-hospital duty hours and call schedules must ensure that residents are not regularly required to perform excessively prolonged periods of duty and that they have adequate opportunities to rest and study. The actual number of hours worked by residents may vary according to circumstance and requirements of the Residency Review Committee of each specialty. The institution and program director are responsible for monitoring adherence to these principles.

In addition to having a section on working hours and supervision in the general requirements, the ACGME has required each RRC to insert provisions in their special requirements. The specificity of the provisions vary from explicit requirements for duty hours and days off to statements similar to the ABMS alternate language. A majority of the RRCs have adopted the one day out of seven free of duties and an every third night call schedule. The Emergency Medicine RRC sets a maximum working week of 60 hours and the Internal Medicine RRC sets a maximum of 80. The orthopedic RRC has a requirement for a maximum of 80 hours per week while being silent about on-call schedules or a 24-hour off-duty period.

At its September meeting the AAMC Executive Council ratified the ACGME draft, despite knowing that the issue was “dead” because of the ABMS veto. The AAMC took this position because it believed that the ACGME draft was consistent with its previously stated position and because council members felt that the ABMS alternative was too vague. I must admit, however, that a vocal minority within the AAMC governance continues to dissent from the AAMC position, and urges the adoption of language that would not specifically limit residents working hours. As an alternative approach, for example, it has been suggested that the problem of resident fatigue be approached not from the side of working hours, but by making requirements for residents’ rest explicit. A member of the AAMC’s Council of Academic

Societies, speaking as a representative of the academic surgery community, suggested language along these lines: "Every resident involved in direct responsibility for the care of patients shall be assured of a minimum of 56 hours each week (average 8 hours pre day) of sleep-rest time, available in blocks of at least 4 hours each, during which the resident must be free of any obligation for involvement in patient care." Personally, I consider this suggestion untenable. In view of the fact that there are 168 hours in the work week, this plan by implication mandates a work week of 112 hours or two thirds of the available hours in the week. I do not think this is a rational option.

CFMA PROPOSAL

On October 10, 1990 the Council for Medical Affairs, which consists of the CEO's and presidents of AMA, AHA, AAMC, ABMS, and CMSS (Council of Medical Specialty Societies), developed an alternative version of the disputed section of the general requirements section of the ACGME:⁶

Each residency program must establish formal policies governing resident duty hours and working environment that are optimal for both resident education and the care of patients.

(a.) Special Requirements relating to duty hours and on-call schedules shall be based on an education rationale and patient need, including continuity of care.

(b.) Resident duty hours and on-call schedules must not be excessive. Absent Special Requirements to the contrary, all residents should on average, be able to have at least one 24 hour day out of seven free of patient care responsibilities and should be on call in the hospital no more often than every third night when averaged over a four-week period.

(c.) The educational goals of the program and learning objectives of residents must not be compromised by excessive reliance on residents to fulfill institutional service obligations. Duty hours, however, must reflect the fact that responsibilities for continuing patient care are not automatically discharged at specific times. Programs must ensure that residents are provided backup support when patient care responsibilities are especially difficult or prolonged.

CONCLUSION

Some of the provisions enunciated in the AAMC's 1988 position paper have been adopted or included in the provisions for the general and special requirements. However, the issue of limiting residents' working hours continues to cause a schism among the various specialties. Surgical specialties are resistant to any provision that allows residents to fail to see the patients for whom they are responsible every day. However, the alternate language for section II.C.A., submitted by ABMS, is considered to be so nonspecific as to be unenforceable. The alternate version developed by the CFMA allows each

RRC to establish its own policies in its special requirements. If this version is supported by the leadership of all five sponsoring organizations it may be possible to achieve a consensus that incorporates residents' working hours as an explicit part of the profession's self-regulation of graduate medical education.

It is my personal view that in a society where most of the work force deals with a 40-hour work week and many industries are talking about 30 to 35 hours, arguments that call for work weeks in excess of 80 hours are unrealistic. At the same time I have great sympathy for the fact that some residents should see their patients every day. I believe this can be accomplished within the 80-hour work week and that is precisely the reason why AAMC's recommendations have not included the 24-hour-a-week-off clause. I also think that, with a bit of innovation, the every third night assignment about which the surgeons seem to feel strongly, can be retained. In short, I do not believe that an 80-hour-a-week requirement is unduly onerous, and can be achieved in all disciplines without sacrificing the principle of continuity of patient care.

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